

January 22, 2019

To Whom it May Concern,

After reviewing the draft of *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*, I would be remiss not to question it's lack of focus on patient record matching. It can be argued that patient record matching is key to improving patient safety and interoperability, two undertakings that can vastly reduce clinical burden.

A lack of standardized patient record matching continues to be a huge burden in our healthcare delivery system. Not only does it reduce the value of information placed in our EHRs but it also diverts the "precious clinical and financial resources" (ONC 4) away from patient care. For example, lack of matching has led to many reported incidents where clinicians have provided treatment to the wrong patient or mistakenly put a test into another patient's electronic health record (EHR).

Supporting the above points are two reports that have been released within the last year. In October 2018, the Joint Commission released a national advisory on avoiding patient identification and matching errors. In addition to this, the Pew Charitable Trusts released a report that asserted better patient matching leads to effective data exchange and improved patient care. This report found that match rates can be as low as eighty percent, which means that one out of every five patients may not be matched to all of his or her records. These numbers are even lower when providers are attempting to match records shared between different entities. They can even be as low as fifty percent when providers are attempting to match using the same EHR vendor.

While I agree with the three points of focus in the strategy outline, I believe there should be one more on patient record matching. Simply to ignore this would not only prevent interoperability, it would increase providers' administrative and clinical burdens by exacerbating patient safety challenges that already require ample time to solve.

Warm Regards,

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